HANNAH'S HEALING

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INTAKE FORM

Today's date:				Primary Care Physician:
CLIENT INFORMATION				
Last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Cell phone no.: ( )	Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:	
Occupation:	Employer:	Employer phone no.: ( )		
Referred to clinic by (please check one box):	❑ Dr.	❑ Business Card	❑ Website	
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other
Other family members seen here:				

I am requesting the following services:

❑ Individual Counseling ❑ Couples Counseling ❑ Family Counseling ❑ Counseling for my child ❑ Other

REQUESTING COUNSELING FOR CHILDREN					
Childs Name:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Currently take medication	❑ Yes ❑ No				
School:	Special Education: ❑ Yes ❑ No	Grade Level:	School Phone Number: ( )		
I give you permission to release information to the school my child attends	❑ Yes ❑ No				
Childs Name:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Currently take medication	❑ Yes	❑ No		Currently take medication	❑ Yes
School:	Special Education: ❑ Yes ❑ No	Grade Level:	School Phone Number: ( )		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I understand that I am financially responsible for any unpaid balance due to a missed appointment that is not cancelled within 24 hours. balance.			
Patient/Guardian signature		*Date*	